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Arizona Industrial Commission
800 West Washington Street
Phoenix, AZ 85007

Re: Staff Proposal 2019/2020 Arizona Physicians' and Pharmaceutical Fee Schedule

Dear Chairman Schultz and Commissioners:

Thank you for the opportunity to provide written comments on the staff proposal. Mitchell International is a leading provider of services in workers' compensation systems across the country. Our services include, but are not limited to, electronic claims reporting, e-billing, bill review, utilization review, independent medical review, data reporting, managed medical care, pharmacy billing services and managed pharmacy care. Our government affairs and compliance teams have over a century of combined experience in working on regulatory and legislative issues in all 50 states and Canada. Of particular relevance to the staff proposal, our government affairs team has pioneered policy related to physician dispensing, compounded medications and drug formularies at a national level. We have been actively engaged with the National Council of Insurance Legislators (NCOIL) aiding in developing model legislation and have been involved with Florida, Pennsylvania, Texas, Tennessee, California and other states in shaping recent legislative and regulatory policy related to these issues. Our overarching goal as an organization is to help ensure that injured workers receive the most appropriate, best-quality and best-value care available to treat their workplace injury or sickness.

We preface our remarks by noting that we have reviewed the staff proposal and are supportive of the reimbursement and policy changes proposed related to pharmaceutical care. Studies and our experience and data show that there are excessive costs, with no commensurate benefit to outcomes, associated with prescription medications when dispensed in environments that are not accessible to the general public. The Commission cited two study examples in the public hearing – the Jeffrey White study on physician dispensed medications in Illinois, published by the *Journal of Occupational and Environmental Medicine* in May of 2014, and their own Arizona data from 2018 provided by NCCI. The Workers' Compensation Research Institute (WCRI) has conducted studies related to physician dispensing and the associated costs. Also, CopperPoint's

data-driven research illustrates the challenges carriers and employers face related to the dispensing of medications in settings not accessible to the general public.

- The White study in Illinois found that when a physician dispensed any medication to a patient within the first 90 days following a date of injury, days of lost time increased to 85 days, compared to 64 days for claims when all prescriptions were received from a traditional pharmacy, and medical costs were 39% higher. If the medication dispensed was an opioid, the lost days increased to 122 days, compared to 66 days if the opioid was dispensed by a pharmacy, and the medical costs were 78% higher.
- WCRI published a study in July of 2012, indicating that physician dispensed medications cost anywhere from 60 to 300% more than the same medications dispensed by a traditional retail pharmacy. Several states have initiated price controls only through fee schedule changes, requiring the use of the original manufactured product's NDC. However, in follow up studies, WCRI found that those price controls erode over time as re-packagers find ways around the controls, including the development of "boutique" drugs of unique strengths that are not sold in pharmacies and only available through physician dispensers (see WCRI Issue Brief – Multistate Perspective on Physician Dispensing, July 2017).
- In 2014, Pennsylvania passed legislation placing time limits on physician dispensing to injured workers – 30 days for any medication and 7 days for opioids. A study released by WCRI in May of 2018, indicated that the time limits did reduce the costs for physician dispensing from a high of 51% of system pharmacy costs to 4% following the passage of the legislation. However, that same study found a shift to the prescribing of high cost compounded medications that was negating the impact of the physician dispensing reforms (see WCRI – Monitoring Physician Dispensing Reforms in Pennsylvania, May 2018).

Our comments are directed at the Pharmaceutical Fee Schedule and related to the specific rule provisions as follows:

Section II – Definitions: We support the proposed changes and additions to the definitions.

Section III – Guidelines for Billing and Reimbursement of Prescription Medications: We support the conditions required to qualify for reimbursement, specifically the use of the original manufacturer NDC noted in (E), the allowance of contracted rates noted in (F), and the changes related to non-traditional strengths found in (K). With regard to the non-traditional strengths, the WCRI study noted above and our own experience has found that some re-packagers providing services to dispensing physicians worked with manufacturers to develop "boutique" strengths with a unique manufacturer's NDC and a wholesale price that was often three to five times or more higher than a similar drug of either lesser or greater strength dispensed from a traditional pharmacy. The "boutique" drugs were only available through a dispensing physician.

Section IV – Billing and Reimbursement for Repackaged Medications: We support the proposed language in this section, specifically the provision requiring use of the NDC of the original product

to determine the average wholesale price (AWP), and the application of the current fee schedule methodology to determine reimbursement. We also support the inclusion of the language for co-pack ingredients without an NDC.

Section V – Billing and Reimbursement for Compound Medications: We support the language in this section, noting strong support for the reimbursement limits set forth in (F). In our experience, we have seen invoices for a 30-day supply of compounded medications exceeding several thousand dollars. The author of these comments has personally spoken with a number of pharmacists around the country who compound medications for their patients and they indicate that their average price for a 30-supply of medication, including topicals, is approximately $125.00. The $200 ceiling should be adequate to cover costs in most cases.

Section VI – Billing and Reimbursement for Medications Administered by a Medical Practitioner: We support the language in this section.

Section VII – Reimbursement for Medications Dispensed by a Medical Practitioner or in a Pharmacy Not Accessible to the General Public: Because each section has some unique conditions we will comment on each sub-section individually:

- **(A)** – We support the conditions indicated to qualify for reimbursement. The one-time, 10-day supply of medication dispensed within seven days of the date of injury should be sufficient to handle any urgent situations that would justify dispensing by a physician. In most cases, an injured worker will have multiple retail pharmacies in closer proximity to their home or workplace than their physician and in most cases will have access to a mail-order option. Outside of an immediate and urgent need at an initial visit closely following the injury, the "convenience" factor often cited by proponents of physician dispensing really isn't present. This is even more true when dealing with refills, since most injured workers will pass several pharmacies while driving to their doctor's office and will incur the cost of another office visit to obtain the refill. If there is an extreme case that requires an exception, that exception could be handled through the pre-approval process outlined in subsection (D). During the hearing, there was a suggestion that the trigger date be the date of the initial visit. While we understand the request, it poses one significant technological challenge and a philosophical challenge. From a technological perspective, the date of initial visit is not a data element that is supported in either the NCPDP D.0 electronic billing format or the NCPDP WC/PC UCF paper billing form so it would be extremely difficult to manage that date. From a philosophical perspective, if the argument for physician dispensing is to handle an urgent and immediate need, the further removed the initial visit is from the actual date of injury the less urgent, it would seem, the injury might be. This is another situation where, if there was a unique circumstance, the provider could seek pre-approval or, if they are a contracted provider, build some provisions into their contract. During the hearing and in some written comments, there was an idea floated that the use of the ODG formulary would somehow control costs. The purpose of ODG and its associated formulary is to provide guidance and recommendations on best practices related to treating injured workers. It may control costs related to over-utilization of medications but cannot control costs related

to the drugs themselves. A recent example can be found in Texas. Prior to the adoption of the ODG formulary in Texas, the Division of Workers' Compensation was wrestling with complaints about the high cost of compounded medications. Many of the compounds contained "N" drug ingredients. When Texas implemented ODG, there was an immediate and precipitous drop in the use of compounds containing "N" drugs. However, there was an immediate spike in the use and cost of compounded medications using all "Y" drug ingredients. So much so that after numerous complaints and following their own independent study, the DWC adopted a rule last year that requires all compounded medications be pre-authorized before being prescribed. While this example applies to compounds, it does illustrate that ODG is not effective at controlling prices. Some have argued that the use of the original manufacturer NDC combined with the fee schedule is enough to control prices so the time limit is not necessary. This is not true for several reasons. Traditional and mail-order pharmacies working with pharmacy benefit managers (PBM) are able to determine the lowest cost therapeutically equivalent medications to dispense to an injured worker. There can often be a wide range of pricing among different generic versions of the same drug even within a single pharmacy. Additionally, ODG often recommends several different medications for treating a specific condition. One of the recommendations may be more efficacious that the others. A dispensing physician is not likely to have the breadth of inventory found at a traditional pharmacy so if the physician is only prescribing medications he or she can dispense, will the injured worker have access to the most efficacious or cost-effective medication? There have also been claims that limiting physician dispensing will reduce access to care and interferes with the doctor-patient relationship. These are also false claims. Several states have already implemented restrictions on physician dispensing. California, Tennessee, Kentucky, and Montana require prior authorization before a physician can dispense outside of an initial fill. Texas, Montana, New York, Utah and several other states prohibit physician dispensing. While the restrictions in Kentucky and Montana are new, none of the other states have had any reported issues with access to care. Additionally, data from Arizona suggests that only five or six practitioners are responsible for nearly 90% of all physician-dispensed medications in the state's workers' compensation system. As previously stated, injured workers obtaining medications from their physician may actually have less access to medications due to a limited inventory at the physician's office. It is also important to note that through rulemaking and legislation, states regularly define the rules around scope of practice and what doctors can and can't do. The opioid legislation passed in Arizona in early 2018 is a recent example. The Arizona Medicaid system prohibits doctors from dispensing medications, as do most commercial health plans. If physician dispensing added such great value, it would stand to reason that the Arizona Medicaid system and commercial health plans would embrace the practice. No one has presented a legitimate study indicating outcomes are better when physicians dispense medications. Again, as stated above, if there are exceptional situations of such urgency that dispensing outside of the time limits set forth in this proposal is warranted, those instances can be handled through a pre-approval process or through a contract.

- **(B)** – We support the allowance for physician dispensing when the three conditions have been met.
- **(C)** – We support the conditions established for reimbursement for medications upon discharge from an in-patient facility.
- **(D)** – We support the language of this provision that would allow for the occasional exception for unique situations with pre-approval or for an on-going contractual relationship to allow for dispensing from non-public settings.
- **(E)** – We support this provision.
- **(F)** – We support the reimbursement guidelines for over-the-counter medications.
- **(G)** – We support this provision as it is standard practice for most practitioners today.

Section VIII – Dispensing Fee: We support this provision as drafted.

Section IX – Additional Billing Guidelines: We support the use of the billing guidelines for the CMS 1500 and the use of the NCPDP WC/PC Universal Claim Form.

Finally, we would like to address a couple of general issues. There have been some complaints that the Commission did not use an open or inclusive process or that they should have gathered all the stakeholders in one room to negotiate. We disagree with those comments. We were present at the legislative hearing, we submitted comments for last year's hearing and we were notified of this staff proposal for comment and participated in the hearing on July 1. We requested an in-person meeting with staff last year and that request was granted. There has not been any time where we have experienced a lack of access to staff or the Commission. We don't believe a negotiating session would have been productive or changed the outcome of the proposal. The data speaks for itself.

There was also a suggestion that the legislation called for the Commission to review and propose a solution but that the final rule should be done as a bill in the legislative process. Having been involved at the legislative hearing and with Senator Fann, we note that the opponents of this proposal argued back in 2018, when SB1111 was being heard, that the Industrial Commission was better suited to take public testimony and craft the final rule, thus delaying the outcome until now. We agreed with that assertion and supported the amendment to facilitate that process. The language in SB1111 is clear in its intent that the Industrial Commission engage stakeholders, research the issue and adopt any changes that their research indicated should be made. For over a year the Commission sought information and has now presented this proposal. To suggest that this now go before the legislature is just another tactic to delay the implementation of the rule.

We commend the Commission for the thorough and thoughtful process. We appreciate being able to share our experience from other states. This proposal doesn't plow new ground in the workers' compensation world, but simply harvests best practices from other states that have had to tackle these very same issues. The proposal outlines reasonable accommodations in the days following the injury and allows for reasonable exceptions through a pre-approval or contracting

process. Again, we express our support for the staff proposal as drafted. If you have any questions about our comments or would like any additional information, please contact Brian Allen, vice president of government affairs, at Brian.Allen@mitchell.com or at 801-903-5754.

Sincerely,

Brian Allen
Vice President Government Affairs